

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07296

7315  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Infant Boy Alvey</b>		4. DATE OF DEATH Month <b>6</b> / Day <b>30</b> / Year <b>1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/30/1960</b>
9. AGE (In years last birthday) <b>0</b> yrs. <b>0</b> Months <b>0</b> Days <b>7</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leonard Jackson Alvey</b>		14. MOTHER'S MAIDEN NAME <b>Lois Ann Guy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Leonard J. Alvey - Leonardtown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital heart malformation (patent foramen ovale)</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 30, 1960</b> , to <b>June 30, 1960</b> , that I last saw the deceased alive on <b>June 30, 1960</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b> DATE SIGNED <b>6/30/60</b>			
ACTUAL SIGNATURE <b>P.J. Bean, MD</b>		Great Mills, Md.	
PHYSICIAN'S NAME (Type) <b>P.J. Bean, MD</b>		Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/1/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07297  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Patuxent River</b> c. LENGTH OF STAY IN 1b <b>Patuxent River</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNAS, Station Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River, Maryland</b> d. STREET ADDRESS <b>Patuxent River, Maryland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pierre</b> Middle <b>George</b> Last <b>ARNOLD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-32</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crash Crew</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Douglas John KELM</b>		14. MOTHER'S MAIDEN NAME <b>Florence Pligye LEACH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>469 20 0243</b>	
17. INFORMANT <b>Official U.S. Navy Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>864X</b> IMMEDIATE CAUSE (a) <b>INJURIES, MULTIPLE, EXTREME</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>stating the underlying cause last.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Crash Crew - struck by aircraft debris</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:50</b> Hour a. m. <b>June 7</b> 19 <b>60</b> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>USNAS, Patuxent River, Md</b>		20f. (City or town) (County) (State) <b>St. Mary's, Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . <b>S.D. HARMON, JR., MC USNR, STATION HOSP., USNAS, PATUXENT RIVER, MD</b> ACTUAL SIGNATURE <b>Wm. D. BOYD, MD</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Wm. D. BOYD, MD</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>7 June 1960</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial ?</b>		22b. DATE THEREOF <b>6-9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Shakopee, Minn.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUN 13 60</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

MARTIAL STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED (Print name in full)		SEX (Print sex)	
DATE OF BIRTH (Print date)		PLACE OF BIRTH (Print place)	
OCCUPATION (Print occupation)		CAUSE OF DEATH (Print cause)	
MANNER OF DEATH (Print manner)		MEDICAL HISTORY (Print history)	
PREVIOUS ILLNESS (Print illness)		MEDICAL OPINION (Print opinion)	
SIGNATURE OF EXAMINER (Print signature)		DATE (Print date)	
PLACE OF EXAMINATION (Print place)		COUNTY (Print county)	
CITY (Print city)		STATE (Print state)	
ZIP CODE (Print ZIP code)		TELEPHONE (Print telephone)	
HOSPITAL (Print hospital)		PHYSICIAN (Print physician)	
NURSE (Print nurse)		PATHOLOGIST (Print pathologist)	
CORONER (Print coroner)		JURY (Print jury)	
OTHER (Print other)		REMARKS (Print remarks)	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G266 7-5-60 et

Reg. Dist. No. 07298

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Long Island</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mechanicsville Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smith Town</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>12 Wild Wood Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Walter</b> Last <b>Barresi</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 13, 1917</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grumman Aircraft</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthonino Barresi</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Movearo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Florence Barresi</b>		Address <b>12 Wild Wood Lane Smith Town, N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>4</b> Hour <b>a. m.</b> <b>6/22 19 60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Md St. Rt 235</b>	20f. (City or town) (County) (State) <b>Mechanicsville, St. Mary's Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M.D.</b>		DATE SIGNED <b>6/22/60</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Buried</b>	22b. DATE THEREOF <b>6/27/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Pine Lawn</b>	22d. LOCATION (City, town, or county) (State) <b>New York</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Orlando R. Davis</b>		ADDRESS <b>Smithtown, Long Island New York</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 24 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7316

## CERTIFICATE OF DEATH

07299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				e. STREET ADDRESS <b>Rural</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANN</b> Middle <b>MORGAN</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/1885</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph F. Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Leigh Edelen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>R. Bascom Brown, Jr. - Leonardtown, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> <b>904.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of the pelvis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell at home</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>3 06.22 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Leonardtwn Maryland</b>	
21. I certify that I attended the deceased from <b>6:22</b> , 19 <b>60</b> , to <b>6:26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6-26</b> , 19 <b>60</b> , and that death occurred at <b>10:30 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtwn, Md.</b> DATE SIGNED <b>6/27/60</b>							
ACTUAL SIGNATURE <b>A. Samadi M.D.</b>				PHYSICIAN'S NAME (Type) <b>A. Samadi, MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE JUL 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07300

7326

Film G267 7-19-60 et

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mississippi</u> b. COUNTY <u>? 61X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>USNAS, PATUXENT RIVER</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USNAS (Station Hospital)</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jackson</u>	
		d. STREET ADDRESS <u>372 Mason St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clyde</u> Middle <u>A</u> Last <u>CHATHAM</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1935</u>
		9. AGE (In years last birthday) <u>25</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Air Force</u>	11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>
		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clyde R. Chatham</u>		14. MOTHER'S MAIDEN NAME <u>Lottie A. (Last name unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>6-60</u>	17. INFORMANT Address <u>  </u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INJURIES, MULTIPLE, EXTREME</u> DUE TO <u>860X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Air Crewman in helicopter struck by naval aircraft (F8U).</u>	
20c. TIME OF INJURY Hour <u>3:50</u> p. m. Month, Day, Year <u>June 7 19 60</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>USNAS, Patuxent River, Md.</u>	20f. (City or town) (County) (State) <u>St. Mary's, Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S.D. Harmon</u> S.D. HARMON, LT MC USN, Station Hospital, USNAS, PATUXENT RIVER, MD		DATE SIGNED <u>7 June 1960</u>	
EXAMINER'S NAME (Type) <u>Wm. D. BOYD MD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedarlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Jackson Mississippi</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi Funeral Home, 816 H St., NE, Wash. 2</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH 1. CITY 2. STATE		DECEASED'S NAME 3. LAST 4. FIRST 5. MIDDLE	
DATE OF DEATH 6. MONTH 7. DAY 8. YEAR		AGE 9. YEARS 10. MONTHS 11. DAYS	
SEX 12. MALE 13. FEMALE		RACE 14. WHITE 15. NEGRO 16. OTHER	
EDUCATION 17. GRADE 18. YEARS		OCCUPATION 19. TRADE 20. PROFESSION	
MARRIAGE 21. SINGLE 22. MARRIED 23. DIVORCED 24. WIDOWED		RELIGION 25. METHODIST 26. ROMAN CATHOLIC 27. OTHER	
BIRTH 28. MONTH 29. DAY 30. YEAR		PLACE OF BIRTH 31. CITY 32. STATE	
MOTHER'S NAME 33. LAST 34. FIRST 35. MIDDLE		FATHER'S NAME 36. LAST 37. FIRST 38. MIDDLE	
MOTHER'S BIRTH 39. MONTH 40. DAY 41. YEAR		FATHER'S BIRTH 42. MONTH 43. DAY 44. YEAR	
MOTHER'S PLACE OF BIRTH 45. CITY 46. STATE		FATHER'S PLACE OF BIRTH 47. CITY 48. STATE	
MOTHER'S MARRIAGE 49. SINGLE 50. MARRIED 51. DIVORCED 52. WIDOWED		FATHER'S MARRIAGE 53. SINGLE 54. MARRIED 55. DIVORCED 56. WIDOWED	
MOTHER'S EDUCATION 57. GRADE 58. YEARS		FATHER'S EDUCATION 59. GRADE 60. YEARS	
MOTHER'S OCCUPATION 61. TRADE 62. PROFESSION		FATHER'S OCCUPATION 63. TRADE 64. PROFESSION	
MOTHER'S RELIGION 65. METHODIST 66. ROMAN CATHOLIC 67. OTHER		FATHER'S RELIGION 68. METHODIST 69. ROMAN CATHOLIC 70. OTHER	
MOTHER'S BIRTH 71. MONTH 72. DAY 73. YEAR		FATHER'S BIRTH 74. MONTH 75. DAY 76. YEAR	
MOTHER'S PLACE OF BIRTH 77. CITY 78. STATE		FATHER'S PLACE OF BIRTH 79. CITY 80. STATE	
MOTHER'S MARRIAGE 81. SINGLE 82. MARRIED 83. DIVORCED 84. WIDOWED		FATHER'S MARRIAGE 85. SINGLE 86. MARRIED 87. DIVORCED 88. WIDOWED	
MOTHER'S EDUCATION 89. GRADE 90. YEARS		FATHER'S EDUCATION 91. GRADE 92. YEARS	
MOTHER'S OCCUPATION 93. TRADE 94. PROFESSION		FATHER'S OCCUPATION 95. TRADE 96. PROFESSION	
MOTHER'S RELIGION 97. METHODIST 98. ROMAN CATHOLIC 99. OTHER		FATHER'S RELIGION 100. METHODIST 101. ROMAN CATHOLIC 102. OTHER	

1  
FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 15. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07301

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Leonardtown</b>	
		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Paul Elmer Connelly</b>		4. DATE OF DEATH Month Day Year <b>June 9, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 17, 1924</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fillmore Connelly</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Shore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578 26 1843</b>	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HANGED</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Climbed up tree &amp; hanged self with strap</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:30</b> <b>6-9 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>FARM</b>	20f. (City or town) (County) (State) <b>LEONARDTOWN St Mary's Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William D. Boyd M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 11.60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>	22d. LOCATION (City, town, or country) (State) <b>Leonardtown, Maryland</b>
23. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
ADDRESS <b>Leonardtown, Maryland</b>		DATE <b>JUN 20 '60</b>	

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1957

1957



RECEIVED

William H. Boyer

1957

William H. Boyer

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07302

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Item 9-11-66 7-5-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown, Md</b>		c. LENGTH OF STAY IN 1b <b>16</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Curtis</b> Last <b>19 60</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>?? ? Approx.</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.	11. IF UNDER 24 HRS. Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>??</b>		14. MOTHER'S MAIDEN NAME <b>??</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>331X</b> DUE TO <b>Cerebral Vascular Accident</b> DUE TO <b>Generalized Arteriosclerosis</b> DUE TO <b>26 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 19 60</b> to <b>June 26 60</b> that (I) (we) last saw the deceased alive on <b>26 June 60</b> and that death occurred at <b>9 M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Ernest M. Rehm</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest Rehm M.D.</b>		22d. ADDRESS <b>Lexington Park</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/30/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>John Westley Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chaptico, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		25a. REC'D BY REGISTRAR <b>JUL 1 '60</b>	
ADDRESS <b>Leonardtown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



100-308

MAINTAINING A RECORD OF DEATHS

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>St. Marys</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>6 wks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>			
				d. STREET ADDRESS <b>Rural</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>PAUL THEOPHILUS DAVIS</b>				4. DATE OF DEATH Month Day Year <b>June 5 19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 August 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Paul Davis</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Sayre</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 14 8762</b>		17. INFORMANT <b>Susie R. Davis - Ridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute hemorrhage, post op., late (4w)</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Abdominopelvic resection - 87m</b> DUE TO (c) <b>Ca of rectum</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Leonardtwn, Md. 6/6/60</b>							
ACTUAL SIGNATURE <b>Michael Barbarich</b> M.D.				DATE SIGNED <b>6/6/60</b>			
PHYSICIAN'S NAME (Type) <b>Michael Barbarich, MD</b>				ADDRESS <b>Leonardtwn, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINE STATE DEPARTMENT OF HEALTH - BATHING 13

CERTIFICATE OF DEATH

1. NAME OF DECEASED MICHAEL BERNARD		2. SEX MALE		3. AGE 35	
4. DATE OF DEATH JULY 15, 1915		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. DISEASE OR INJURY CORONARY ARTERY DISEASE		9. PERIOD OF ILLNESS 2 WEEKS	
10. OCCASION OF DEATH SUDDEN		11. PLACE OF BIRTH NEW YORK		12. DATE OF BIRTH JULY 1, 1880	
13. NAME OF FATHER JOHN BERNARD		14. NAME OF MOTHER MARY BERNARD		15. NAME OF SPOUSE ANNE BERNARD	
16. NAME OF MINISTER PASTOR		17. NAME OF CLERGYMAN PASTOR		18. NAME OF FUNERAL HOME PASTOR	
19. NAME OF BURIAL PLACE CATHOLIC		20. NAME OF CEMETERY CATHOLIC		21. NAME OF FUNERAL HOME PASTOR	
22. NAME OF FUNERAL HOME PASTOR		23. NAME OF FUNERAL HOME PASTOR		24. NAME OF FUNERAL HOME PASTOR	
25. NAME OF FUNERAL HOME PASTOR		26. NAME OF FUNERAL HOME PASTOR		27. NAME OF FUNERAL HOME PASTOR	
28. NAME OF FUNERAL HOME PASTOR		29. NAME OF FUNERAL HOME PASTOR		30. NAME OF FUNERAL HOME PASTOR	
31. NAME OF FUNERAL HOME PASTOR		32. NAME OF FUNERAL HOME PASTOR		33. NAME OF FUNERAL HOME PASTOR	
34. NAME OF FUNERAL HOME PASTOR		35. NAME OF FUNERAL HOME PASTOR		36. NAME OF FUNERAL HOME PASTOR	
37. NAME OF FUNERAL HOME PASTOR		38. NAME OF FUNERAL HOME PASTOR		39. NAME OF FUNERAL HOME PASTOR	
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43. NAME OF FUNERAL HOME PASTOR		44. NAME OF FUNERAL HOME PASTOR		45. NAME OF FUNERAL HOME PASTOR	
46. NAME OF FUNERAL HOME PASTOR		47. NAME OF FUNERAL HOME PASTOR		48. NAME OF FUNERAL HOME PASTOR	
49. NAME OF FUNERAL HOME PASTOR		50. NAME OF FUNERAL HOME PASTOR		51. NAME OF FUNERAL HOME PASTOR	
52. NAME OF FUNERAL HOME PASTOR		53. NAME OF FUNERAL HOME PASTOR		54. NAME OF FUNERAL HOME PASTOR	
55. NAME OF FUNERAL HOME PASTOR		56. NAME OF FUNERAL HOME PASTOR		57. NAME OF FUNERAL HOME PASTOR	
58. NAME OF FUNERAL HOME PASTOR		59. NAME OF FUNERAL HOME PASTOR		60. NAME OF FUNERAL HOME PASTOR	
61. NAME OF FUNERAL HOME PASTOR		62. NAME OF FUNERAL HOME PASTOR		63. NAME OF FUNERAL HOME PASTOR	
64. NAME OF FUNERAL HOME PASTOR		65. NAME OF FUNERAL HOME PASTOR		66. NAME OF FUNERAL HOME PASTOR	
67. NAME OF FUNERAL HOME PASTOR		68. NAME OF FUNERAL HOME PASTOR		69. NAME OF FUNERAL HOME PASTOR	
70. NAME OF FUNERAL HOME PASTOR		71. NAME OF FUNERAL HOME PASTOR		72. NAME OF FUNERAL HOME PASTOR	
73. NAME OF FUNERAL HOME PASTOR		74. NAME OF FUNERAL HOME PASTOR		75. NAME OF FUNERAL HOME PASTOR	
76. NAME OF FUNERAL HOME PASTOR		77. NAME OF FUNERAL HOME PASTOR		78. NAME OF FUNERAL HOME PASTOR	
79. NAME OF FUNERAL HOME PASTOR		80. NAME OF FUNERAL HOME PASTOR		81. NAME OF FUNERAL HOME PASTOR	
82. NAME OF FUNERAL HOME PASTOR		83. NAME OF FUNERAL HOME PASTOR		84. NAME OF FUNERAL HOME PASTOR	
85. NAME OF FUNERAL HOME PASTOR		86. NAME OF FUNERAL HOME PASTOR		87. NAME OF FUNERAL HOME PASTOR	
88. NAME OF FUNERAL HOME PASTOR		89. NAME OF FUNERAL HOME PASTOR		90. NAME OF FUNERAL HOME PASTOR	
91. NAME OF FUNERAL HOME PASTOR		92. NAME OF FUNERAL HOME PASTOR		93. NAME OF FUNERAL HOME PASTOR	
94. NAME OF FUNERAL HOME PASTOR		95. NAME OF FUNERAL HOME PASTOR		96. NAME OF FUNERAL HOME PASTOR	
97. NAME OF FUNERAL HOME PASTOR		98. NAME OF FUNERAL HOME PASTOR		99. NAME OF FUNERAL HOME PASTOR	
100. NAME OF FUNERAL HOME PASTOR		101. NAME OF FUNERAL HOME PASTOR		102. NAME OF FUNERAL HOME PASTOR	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Deal</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Lexington Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Temporary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Jefferson EBERLE</b>		4. DATE OF DEATH Month Day Year <b>June 1 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 April 1934</b>
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army Sp4</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Joseph Eberle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kathleen Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Not Obtainable</b>	
17. INFORMANT <b>Wife:</b>		Address <b>Angelina Eberle, 105 Poplar Ave, Deal, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Skull Fracture &amp; Fracture Neck</b> 822-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident - overturned in roadway</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:00 p. m. June 1, 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Willow Road</b>		20f. (City or town) (County) (State) <b>St. Mary's, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>W. H. Patrick</b>		DATE SIGNED <b>2 June 1960</b>	
EXAMINER'S NAME (Type) <b>W. H. PATRICK, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/6/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	22d. LOCATION (City, town, or county) (State) <b>Long Branch, New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 6 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07305

7319  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>St. Inigoes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CECELIA B. GREEN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b>00</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>Edgar Biscoe</b>		16. MOTHER'S MAIDEN NAME <b>Nora Smith</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>-----</b>	
19. INFORMANT <b>Sarah Ramsey-</b>		Address <b>102 Kearney Ave. Jersey City N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Fractured Femur</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>10-20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 18, 1960</b> to <b>June 18, 1960</b> , that I last saw the deceased alive on <b>June 18, 1960</b> , and that death occurred at <b>Lexington Park, Md.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ernest M. Rehm</b>		DATE SIGNED <b>June 22, 1960</b>	
PHYSICIAN'S NAME (Type) <b>Ernest M. Rehm, MD</b>		ADDRESS (Street, city or town, state) <b>Lexington Park, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Inigoes, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson- Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 27 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME  
5M 7/59

1  
FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7329 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Items 4, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1716 Kenyon St. N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Michael Heister Jr.				4. DATE OF DEATH June 6, 1960				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Aug. 21, 1909 9. AGE (In years last birthday) 50 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY ?				11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Heister				14. MOTHER'S MAIDEN NAME Stella Willeke				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 579-03-5038 17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO (b) Laceration of neck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted ST George Island							
20c. TIME OF INJURY Month, Day, Year Hour a.m. June 1 1960 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Prison Part St. Mary's			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/8/60			
EXAMINER'S NAME (Type) William D. [Signature] Boyd M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/10/60				22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			
23. FUNERAL DIRECTOR Collins Funeral Home				ADDRESS 3821 14th St. N.W. Washington, D.C.				24a. REC'D BY REGISTRAR JUN 10 '60 24b. REGISTRAR'S SIGNATURE [Signature]			

THE STATE  
OF NEW YORK  
DEPARTMENT OF HEALTH



Dr. J. H. Smith

Dr. J. H. Smith, M.D.  
1234 Main Street  
New York, N.Y.

Michael

White

White

Robert J.

Aug. 1, 1950

*[Handwritten signature]*



Dr. J. H. Smith

1234 Main Street

New York, N.Y.

D. C.

Continued from page 1 of 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7320

Items 1, 3, 5, 6, 14, 60 et

CERTIFICATE OF DEATH

07307

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>9hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Lucille</b> Last <b>Hodgdon</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1906</b>
9. AGE (In years lost birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mass. Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry P. Burroughs</b>		14. MOTHER'S MAIDEN NAME <b>Emma Suite</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>		16. SOCIAL SECURITY NO. <b>570-5</b>	
17. INFORMANT <b>Natt L. Hodgson</b>		Address <b>54 Coral Place Lexington Park, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO <b>Intestinal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Intestinal obstruction</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>June 4, 1960</b> to <b>June 5, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 5, 1960</b> , and that death occurred at <b>5:00 AM</b> from the causes and on the date stated above. 22a. SIGNATURE <b>P. J. Bean</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>P. J. Bean M.D.</b> 22d. ADDRESS <b>Great Mills, Maryland</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>24 hours</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/8/60</b>	
23c. NAME OF <b>Cedar Hill</b> CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>		ADDRESS <b>Leonardtwn, Maryland</b>	
25a. REC'D BY REGISTRAR <b>JUN 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



7320

CERTIFICATE OF DEATH

0270

Deceased

Married

SA George H. ...

Localio ...

April 1, 1900

Localio

Married

Married

Married

Married

Married

Married ...

Married

Married

Married

Married

Married

Married

Married

Married

Married

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-40. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

7330

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07308

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY <b>Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maddox</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mill Point Shores</b>		d. STREET ADDRESS <b>413 - 17th St. N.E.</b>	
3. NAME OF DECEASED (Type or print) <b>MARGARET JETER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/24/1936</b>
9. AGE (In years last birthday) <b>23</b> yrs.		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Union, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Austin Jeter</b>		14. MOTHER'S MAIDEN NAME <b>Rosetta Dawkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Rosetta Jeter -413-17th St. N.E. Was. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>small boat turned over</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:00 p.m. 6-28-60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wicomico River</b>		20f. (City or town) (County) (State) <b>Maddox St Mary Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.D. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Wm. D. Boyd, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/30/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/1/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spangler Funeral Home</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>524 8th N.E. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>JUL 5 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Robert L. Hester</b>	

7330

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe SEX Male AGE 45 RACE White  
DATE OF DEATH 10-15-1910 PLACE OF DEATH Home  
RESIDENCE 123 Main St. Baltimore, Md.

CAUSE OF DEATH Myocardial Infarction  
MANNER OF DEATH Natural

EDUCATION High School OCCUPATION Teacher  
MARITAL STATUS Married NUMBER OF CHILDREN 3

PREVIOUS ILLNESS None PRESENT ILLNESS None  
HISTORY OF PRESENT ILLNESS None

PHYSICIAN'S NAME Dr. J. H. Smith ADDRESS 456 N. Broadway  
DATE OF EXAMINATION 10-15-1910

TESTIMONY OF MEDICAL EXAMINER  
I, the undersigned, being duly sworn, depose and say that the foregoing is a true and correct statement of the facts and circumstances surrounding the death of the above named deceased.

SUBSCRIBED AND SWORN to before me this 15th day of October, 1910.

Notary Public for the State of Maryland

TESTIMONY OF MEDICAL EXAMINER  
I, the undersigned, being duly sworn, depose and say that the foregoing is a true and correct statement of the facts and circumstances surrounding the death of the above named deceased.

SUBSCRIBED AND SWORN to before me this 15th day of October, 1910.

Notary Public for the State of Maryland

TESTIMONY OF MEDICAL EXAMINER  
I, the undersigned, being duly sworn, depose and say that the foregoing is a true and correct statement of the facts and circumstances surrounding the death of the above named deceased.

SUBSCRIBED AND SWORN to before me this 15th day of October, 1910.

Notary Public for the State of Maryland

## 07309

1. PLACE OF DEATH o. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>		c. LENGTH OF STAY IN 1b <b>26days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt.1 Clements</b>		d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Mark Latham</b>				4. DATE OF DEATH Month Day Year <b>June 23, 1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1902</b>	9. AGE (In years last birthday) <b>57</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>State Road</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Martin Latham</b>				14. MOTHER'S MAIDEN NAME <b>Florence Mattingly</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-22-0622</b>		17. INFORMANT Address <b>Wilhelmina G. Latham Clements</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary - Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1960</b> to <b>June 23, 1960</b> , that (I) (we) last saw the deceased alive on <b>June 23, 1960</b> , and that death occurred at <b>8:15 P.M.</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles Greenwell</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>				22d. ADDRESS <b>Leonardtwn, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		23d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 '60</b>			
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

0330

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000



TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, including names and dates]

[Large block of illegible text, likely a memorandum or report body]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, the day should be written in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7331

07310

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Hollywood</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Philip</b> Middle <b>Herbert</b> Last <b>Miedzinski</b>				4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1943</b>	9. AGE (In years last birthday) <b>16</b> yrs.	IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b>16</b> Min. <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hollywood</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E Miedzinski</b>				14. MOTHER'S MAIDEN NAME <del>Mary Eva McKay</del> <b>Mary Eva McKay</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <b>John E. Miedzinski</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>813X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture skull</b> (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Motor vehicle with bicycle</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:10</b> Hour <b>8:10</b> p.m. <b>6/22/60</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Md. St. Rt. 235</b>		20f. (City or town) (County) (State) <b>Hollywood St. Mary's Md</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>P. J. Bean</b>		M.D. <b>P. J. Bean M.D. Great Mills, Md</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/23/60</b>	
EXAMINER'S NAME (Type) <b>P. J. Bean</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or country) (State) <b>Hollywood, Maryland</b>			
23. FUNERAL DIRECTOR <b>W.C. Mattingley</b>				24e. REC'D BY REGISTRAR <b>DATE JUN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	



# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7332

07312

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b> c. LENGTH OF STAY IN lb <b>1 hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> <b>St. Mary's</b> <b>c. COUNTY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Lexington Park</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>SI SI Sylvester Noland</b> First Middle Last <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Colored</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>July 19, 1947</b> <b>9. AGE</b> (In years last birthday) <b>12</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <b>June 14, 1960</b> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>School child</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Richard Duckett</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Ethel Noland</b> Address		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ethel Noland</b> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>929.8</b> DUE TO <b>Brown Ataxia</b> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) } Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>5</b> Hour a.m. <b>6-14</b> p.m. <b>1960</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office, bldg., etc.) <b>Lexington Park St Mary's Md</b> <b>20f. (City or town)</b> <b>Lexington Park St Mary's Md</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>6/17/60</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Face</b> <b>23. FUNERAL DIRECTOR</b> <b>W. Clarke Mattingley Leonardtown, Maryland</b> ADDRESS		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUN 20 '60</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Hines</b> <b>24c. LOCATION (City, town, or country)</b> <b>Great Mills, Md.</b> (State)	

VS. A15ME  
5M 7/59

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

100-333333

(M)

Subject: [illegible]  
Date: [illegible]  
Place: [illegible]

On [illegible] at [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]  
[illegible] [illegible] [illegible]

(1)

[illegible text block containing multiple lines of text, mostly illegible due to poor scan quality]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07313  
Reg. Dist. No.

7333

1. PLACE OF DEATH a. COUNTY Saint Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, PATUXENT RIVER		c. LENGTH OF STAY IN 1b 21 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X USNAS, PATUXENT RIVER			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS (STATION HOSPITAL)				d. STREET ADDRESS PATUXENT RIVER, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Harry PRIESTER				4. DATE OF DEATH Month Day Year June 7 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-26-40	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospitalman		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Edward PRIESTER				14. MOTHER'S MAIDEN NAME Christena (n) VAN TYLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1957/1960 341 32 4531		17. INFORMANT Address Official U.S. NAVY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURE, DEPRESSED, SKULL, COMPOUND, With Immediate 864X DUE TO Brain Injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aidman in Crash Ambulance which was struck by aircraft					
20c. TIME OF INJURY Month, Day, Year Hour Minute P. M. 3:50 June 7 19 60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS		20f. (City or town) (County) PATUXENT RIVER, MARYLAND	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . Stanley D. Harmon							
ACTUAL SIGNATURE Stanley D. HARMON LT (MC) USN		DATE SIGNED 7 June 1960		USNAS, Patuxent River, Md			
EXAMINER'S NAME (Type) Wm D. BOYD MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/60		22c. NAME OF CEMETERY OR CREMATORY Downers Grove, Minn Ill.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland				24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE C. S. Kneass	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH	
JAMES M. SMITH		Male		45		White		1945		10:30 AM		Home	
8. OCCUPATION		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF FUNERAL HOME		14. SIGNATURE OF MINISTER	
Teacher		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]	
15. HISTORY OF ILLNESS		16. PRESENT ILLNESS		17. TREATMENT		18. POST-MORTEM		19. OTHER		20. REMARKS		21. SIGNATURE OF EXAMINER	
[Text]		[Text]		[Text]		[Text]		[Text]		[Text]		[Signature]	
22. SIGNATURE OF EXAMINER		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF FUNERAL HOME		25. SIGNATURE OF MINISTER		26. SIGNATURE OF EXAMINER		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



RECEIVED  
 BALTIMORE  
 MAY 10 1945

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7334

Reg. 07314

1. PLACE OF DEATH a. COUNTY <b>Saint Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park, Maryland</b>				c. LENGTH OF STAY IN 1b <b>1 yr 9 mos</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNAS (STATION HOSPITAL)</b>				e. STREET ADDRESS <b>PATUXENT RIVER, MARYLAND</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Loren Vincent STALTER</b>				4. DATE OF DEATH Month Day Year <b>June 14 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1941</b>	
9. AGE (In years last birthday) <b>19 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Airman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Bremen, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Deceased</b>				14. MOTHER'S MAIDEN NAME <b>Edna Marie VANATTA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>299344478</b>		17. INFORMANT Address <b>U.S. Navy Official Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INJURIES, Multiple Extreme (8651)</b> <b>822X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs 9 min</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident - overturning in Road</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>2040</b> P. M. <b>6 14 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 235</b>		20f. (City or town) (County) (State) <b>2 Miles So. Lexington Park, Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Lt. Joseph H. MILLER, III MC USNR</b>				DATE SIGNED <b>June 14, 1960</b>			
EXAMINER'S NAME (Type) <b>W. H. PATRICK MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bremen, Ohio</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 20 1960</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7335 Film 6267 7-19-60 et  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07315

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Indiana b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNAS, PATUXENT RIVER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
c. LENGTH OF STAY IN 1b 0		52X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS (Station Hospital)		d. STREET ADDRESS 220 N. 16th St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank WILLIAMS		4. DATE OF DEATH Month Day Year June 7 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1930
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY Ohio	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace L. Williams		14. MOTHER'S MAIDEN NAME Grace F. (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 6-60	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INJURIES, MULTIPLE, EXTREME DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pilot of Air Force Helicopter struck by naval aircraft (F8U).	
20c. TIME OF INJURY Month, Day, Year Hour Min. p. m. June 7 1960		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) USNAS, Patuxent River, Md.		20f. (City or town) (County) (State) St. Mary's, Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . S.D. HARTON, LT MC USN Station Hospital, USNAS, Patuxent River, Md. DATE SIGNED ACTUAL SIGNATURE M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Wm. D. BOYD MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7 June 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-60	
22c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Cem.		22d. LOCATION (City, town, or county) (State) Richmond Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rinaldi Funeral Home, 816 H St., NE, Wash. 2		24a. REC'D BY REGISTRAR DATE JUL 11 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7322

CERTIFICATE OF DEATH

07316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonard town</u>				c. LENGTH OF STAY IN 1b <u>6 hrs. 35 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>boy</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negroid</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 18 1960</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10a.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>James Edward Butler</u>				14. MOTHER'S MAIDEN NAME <u>Wilson, Alice Bertina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>773.5</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> at work _____ Not while <input type="checkbox"/> at work _____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>18 June</u> , 19 <u>60</u> , to <u>18 June</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>18 June 1960</u> , and that death occurred at <u>St. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/18/60</u> ACTUAL SIGNATURE <u>Leon W. Berbue</u> PHYSICIAN'S NAME (Type) <u>Leon W. Berbue M.D.</u> <u>Mechanicsville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		22d. LOCATION (City, town, or county) (State) <u>Compton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Clarke Mattingley Leonardtown, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

2078171XVI



CERTIFICATE OF DEATH

5325

PLACE OF DEATH HOME		DATE OF DEATH 1918	
NAME OF DECEASED JOHN DOE		SEX Male	
AGE 45		OCCUPATION Farmer	
CAUSE OF DEATH Heart Disease		PLACE OF BIRTH Baltimore, Md.	
DATE OF BIRTH 1873		PLACE OF DEATH Baltimore, Md.	
NAME OF DECEASED JOHN DOE		SEX Male	
AGE 45		OCCUPATION Farmer	
CAUSE OF DEATH Heart Disease		PLACE OF BIRTH Baltimore, Md.	
DATE OF BIRTH 1873		PLACE OF DEATH Baltimore, Md.	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7323

## CERTIFICATE OF DEATH

07317

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Leonardtown,</b>				c. LENGTH OF STAY IN 1b <b>1 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Bay</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1960</b>		9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Benjamin Baker</b>				14. MOTHER'S MAIDEN NAME <b>Alice Elizabeth Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph B. Baker Helen, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>769.5</b> DUE TO <b>Inter cranial hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Prematurity</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6/17</b> 19 <b>60</b> to <b>6/17</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> 19 <b>60</b> , and that death occurred at <b>6/17</b> 19 <b>60</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph B. Baker</b>				22b. DATE SIGNED <b>6/20/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Mechanicville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>	
23d. LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR <b>JUN 24 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

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(M)

(1)

1953

CERTIFICATE OF DEATH

0731

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar		10. Signature of informant	
John William Taylor		Male		45		June 17, 1908		June 17, 1953		Home		Heart disease		[Signature]		[Signature]		[Signature]	
11. Place of residence		12. Occupation		13. Marital status		14. Education		15. Religion		16. Race		17. Ethnic group		18. Social class		19. Family size		20. Other remarks	
New York City		Teacher		Married		High School		Catholic		White		Irish American		Middle Class		4		None	